R E P O R T R E S U M E S

ED 017 878 AC 002 293

INSTITUTIONAL CONSTRAINTS ON PROFESSIONALISM, THE CASE OF THE MENTAL HEALTH PROFESSIONS. PAPER PRESENTED AT A NATIONAL SEMINAR ON ADULT EDUCATION RESEARCH (CHICAGO, FEBRUARY 11-13, 1968).

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PUB DATE FEB 68

EDRS PRICE MF-$0.25 HC-$1.60 38P.

DESCRIPTORS- *MENTAL HEALTH, *PROFESSIONAL PERSONNEL, *PROFESSIONAL OCCUPATIONS, *HEALTH PERSONNEL, *MODELS, SURVEYS, WORK ENVIRONMENT, PHILOSOPHY, PROFESSIONAL EDUCATION, PHYSICIANS, PARAMEDICAL OCCUPATIONS, ADMINISTRATION, PROFESSIONAL ASSOCIATIONS, ORGANIZATIONAL CLIMATE, JOB ANALYSIS, METROPOLITAN AREAS, INVESTIGATIONS,

AS PART OF A LARGER STUDY OF CAREERS IN THE MENTAL HEALTH FIELD BEING MADE AT THE UNIVERSITY OF CHICAGO, THIS INVESTIGATION STUDIED (1) A MODEL FOR STUDYING PROFESSIONAL BEHAVIOR, (2) EXTENT TO WHICH PROFESSIONAL, IDEOLOGICAL, AND INSTITUTIONAL FACTORS INFLUENCE PROFESSIONAL FUNCTIONS, AND (3) IMPLICATIONS FOR UNDERSTANDING PROFESSIONAL ADULT EDUCATORS. PROFESSIONAL MENTAL HEALTH PERSONNEL WERE STUDIED BY QUESTIONNAIRE IN METROPOLITAN CHICAGO, LOS ANGELES, AND NEW YORK. LINES OF SPECIALIZATION WERE DRAWN BETWEEN MEDICALLY TRAINED PROFESSIONALS WHO DID THERAPY IN PRIVATE PRACTICE AND NONMEDICAL PROFESSIONALS WHO ENGAGED IN ADMINISTRATION AND NON-INTENSIVE CLIENT CONTACT. AFTER ANALYZING THE PROFESSIONS AND MAJOR JOB ACTIVITIES, IT WAS CONCLUDED THAT KNOWLEDGE OF THE WORK SETTING WAS THE BEST PREDICTOR OF THE DISTRIBUTION OF MENTAL HEALTH PROFESSIONALS IN FIVE OUT OF SIX TYPES OF FUNCTIONS, AND WAS A PREREQUISITE TO UNDERSTANDING THE INFLUENCE OF IDEOLOGICAL ADHERENCE AND PROFESSIONAL TRAINING. IMPLICATIONS FOR RESEARCH IN ADULT EDUCATION INCLUDE THE NEED TO STUDY PROFESSIONAL BEHAVIOR IN THE WORK SITUATION, TO CONCENTRATE ON ORGANIZATIONAL AND SOCIAL CONTROLS, AND TO INCLUDE A METROPOLITAN COMMUNITY IN THE STUDY. THIS PAPER WAS PRESENTED AT A NATIONAL SEMINAR ON ADULT EDUCATION RESEARCH (CHICAGO, FEBRUARY 11-13, 1968). (PT)

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INSTITUTIONAL CONSTRAINTS ON PROFESSIONALISM: THE CASE OF THE MENTAL HEALTH PROFESSIONS*

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*The present investigation is part of a larger study of careers in the mental health field, supported by National Institute of Mental Health Grant No. MH-09192 and directed by Professor William E. Henry of the Committee on Human Development, the University of Chicago.

Paper read at the National Seminar on Research in Adult Education, Chicago, February, 1968

INSTITUTIONAL CONSTRAINTS ON PROFESSIONALISM: THE CASE OF THE MENTAL HEALTH PROFESSIONS

General Objectives

The objectives of this paper are threefold. The first, and most general, objective is to specify the components of a general model for the study of professional behavior--irrespective of the substantive field in which it occurs. The second objective is to describe the types of relationships that obtain between the three components of the model--professional affiliation, ideology and work setting--and assess their influence on professional behavior in one substantive field; namely, the mental health field. In pursuing this objective particular emphasis will be placed on influences on professional behavior emanating from the structural limitations and imperatives of institutional work settings. The final objective, which cannot be achieved until the first two purposes have been fulfilled, is to examine some of the implications of the proposed framework for understanding the behavior of professional adult educators.

Components of the General Model

In attempting to explain the wide range of behavior exhibited by professionals in the mental health field, earlier studies have emphasized, either separately or in combination, three general factors: 1) therapeutic ideologies,[1] 2) professional training and background,[2] and institutional setting.[3] While there has been a general acceptance of these factors as "basic" to an understanding of the professional mental health field, progress in accumulating evidence on their influence has been uneven.

Early studies of the influence of therapeutic ideologies on the distribution of professional functions tended to focus on one profession, psychiatry, and to split orientations into dichotomous categories.[4] Thus, while these investigators obviously felt that therapeutic ideology was a strong influence on the activities of any of the mental health professions their indices of ideology contained items specific to psychiatry.[5] A recent study of therapeutic ideology, however, has broadened the focus to include a limited sample of clinical psychologists and social workers, as well as psychiatrists and divided the orientations into three categories rather than two.[6] Another innovation introduced by this study was considering therapeutic ideologies to be, at least partially, a product of the institutional setting in which the professional worked rather than solely the result of professional training systems. As yet, however, no attempt has been made to determine the full range of therapeutic orientations held by the population of professionals working in an urban "service" area.

A second approach to the study of the allocation of professional services in the mental health field has emphasized professional affiliation and interprofessional relations. The basic assumption in this approach is that professional training systems specify roles and, hence, the key factor in understanding the allocation of functions is professional designation.[7] However, recent writings suggest that in the rapidly expanding mental health field traditional professional specialization is being reduced by increased functional similarity. Thus, while the "official" literature in each of the core mental health professions is rich in attempts to specify the appropriate functions for their personnel, current evidence

hospitalization toward treatment in a wide range of outpatient facilities and other institutions, it is important to determine the extent to which patterns found in hospitals also hold in other organizational settings.[10] Similarly, while there has been a recent proliferation of psychiatric institutions, private practice is still the dominate treatment setting for some of the mental health professions. Clearly, then, any comprehensive understanding of the division of labor in the mental health field must include a consideration of private practice as a work setting.

In general, then, the study of the mental health field still lacks evidence on the extent to which professional, ideological and institutional factors interact to influence the distribution of professional functions. This is particularly true of settings other than hospitals and of professions other than psychiatry. Clearly, what is needed is to move away from the comparative case studies of one or two organizations or professions, which have been so frequent in sociological research in the mental health field, to broader surveys of a wide range of professions, ideologies and settings. As a first step in this direction, this paper presents findings on the influence of professional affiliation, therapeutic ideology and work setting on the division of labor existing in the total population of professionals involved in the treatment of mental illness in three metropolitan communities.

The Sample

The data for this study came from a questionnaire survey of the total population of professional therapeutic personnel working in the Chicago, Los Angeles and New York Metropolitan Communities.[11] The target population consisted of all psychoanalysts, psychiatrists,

clinical psychologists and psychiatric social workers involved in treating mental illness in the three communities. Enumeration of all practicing professionals in each of these groups was accomplished by using professional directories.[12]

Four attempts were made to obtain questionnaires from members of the target populations. These included two mailings with accompanying cover letters, a telephone contact with those who had not returned the questionnaire after the second mailing and, finally, a postal reminder to those respondents who, when contacted by telephone, had agreed to return the form but had failed to do so after three weeks. This resulted in an over-all return rate of approximately sixty per cent. Table 1 presents the return rate for each profession in each of the metropolitan communities.

Insert Table 1 about here

As Table 1 indicates, response to the questionnaire was better in Chicago and Los Angeles than in New York. While there are undoubtedly many reasons for the lower return rates in New York, the major factors appear to be related to the field work itself rather than to characteristics of practitioners. Moreover, while New York differs in aggregate return rate it should be noted that the order of return from the four professions groups is similar in each of the cities. Specifically, in each case the two non-medical professions returned the questionnaire at a higher rate

TABLE 1

QUESTIONNAIRE SURVEY: RETURN RATES BY PROFESSION AND CITY*

	Chicago	Los Angeles	New York	TOTAL
Profession				
Psychoanalysts	63.1% (103) (168)	68.9% (166) (241)	48.5% (369) (761)	54.5% (638) (1170)
Psychiatrists	57.2% (151) (264)	50.8% (214) (421)	40.9% (368) (899)	46.3% (733) (1584)
Clinical Psychologists	77.2% (268) (347)	71.9% (517) (580)	62.1% (780) (1256)	67.1% (1465) (2183)
Psychiatric Social Workers	78.0% (213) (273)	75.1% (217) (289)	64.1% (724) (1130)	68.2% (1154) (1692)
TOTAL	69.9% (735) (1052)	66.2% (1014) (1531)	55.4% (2241) (4046)	60.2% (3990) (6629)

*The percentages in the table represent the proportion of all questionnaires sent to a given profession in a given city which were returned. For example, in Chicago 168 questionnaires were sent to psychoanalysts and 103 or 63.1 per cent of them were completed and returned.

than the medical professionals. To determine whether these differences indicated a systematic bias in our sample we compared the sample of returns with data drawn from the professional directories used to enumerate the professional populations. No appreciable differences were found between the population and sample with regard to sex or age. Further, for psychoanalysts, psychiatrists and clinical psychologists data was available on job titles for both the population and sample. Striking similarity was found between the proportions of returns and non-returns within each professional group that fell in the various job title categories. In general, then, we can assert with some confidence that the data generated by the survey provides a systematic description of the population of professional mental health practitioners in the three cities.

Findings

In an attempt to assess the distribution of functions performed by the various mental health professions we asked the respondents to indicate their major job activity in their current principal position. Table 2 presents the answers given to this question.

Table 2 about here

As expected, the vast majority of psychoanalysts and psychiatrists are engaged in therapy, of one form or another. Further, while both of the nonmedical professions have a more uniform distribution of activities than the medical professions, the traditional functions of counseling for

TABLE 2

DISTRIBUTION OF MAJOR JOB ACTIVITY BY PROFESSION

Major Job Activity	Profession: Psychoanalyst	Psychiatrist	Clinical Psychologist	Psychiatric Social Work	Total*
Therapy[a]	79.1% (462)	64.0% (405)	39.9% (534)	23.1% (248)	45.5% (1649)
Counseling[b]	0.5 (3)	4.9 (31)	22.0 (294)	5.4 (58)	10.4 (386)
Psychiatric Case Work				24.9 (267)	7.6 (267)
Administration	10.8 (63)	20.5 (130)	19.0 (254)	33.6 (360)	22.2 (807)
Teaching	7.9 (46)	6.5 (41)	12.7 (170)	10.8 (116)	10.3 (373)
Research	1.7 (10)	4.1 (26)	6.4 (85)	2.2 (24)	4.0 (145)
Total	100% (584)	100% (633)	100% (1337)	100% (1073)	100% (3627)

[a] This category refers to those engaged in Psychoanalysis, Psychotherapy or Group and Family Therapy as a Major Job Activity.

[b] This category includes Diagnosis as a Major Job Activity.

* No Answer = 365

psychologists and casework for social workers is still the major job activity of more than one out of every five members of each of these professions. Similarly, clinical psychology is the profession most involved in research and teaching activities while administration is the largest single activity for psychiatric social workers. More interesting, perhaps, is the fact that there is not a great deal of overlap in the functions performed by the various professions. This is particularly true of therapy but specialization along professional lines is also evident in the other areas. It seems clear, then, that in spite of the rapid growth of the mental health professions, professional training systems still tend to produce a division of labor in the mental health field.

While professional skills are restricted by professional training systems, the dominant sets of beliefs about mental illness, including the etiology, the nature of treatment and the appropriate treatment settings are available to members of all four professions.[13] Thus, while members of a profession may be similar in terms of the general type of training they have received, they vary widely in terms of the therapeutic ideologies they hold. Also, adherence to a particular ideology may override differences between professions or produce intra-profession differences. For our purposes, the important issue is how the various dominant therapeutic ideologies are related to the distribution of professional functions in the field.[14] Table 3 presents these data.

Table 3 about here

TABLE 3

RELATIONSHIP BETWEEN MAJOR THERAPEUTIC IDEOLOGY AND MAJOR JOB ACTIVITY

Major Job Activity	Major Ideology: Psychoanalytic[a]	Neo-Freudian[b]	Sullivanian[c]	Eclectic[d]	Rogerian Existential[e]	Social Community[f]	Total*
Therapy	52.2% (915)	51.5% (117)	47.6% (90)	41.8% (59)	32.1% (88)	18.5% (77)	44.8% (1346)
Counseling	8.4 (147)	10.6 (24)	16.4 (31)	14.9 (21)	24.1 (66)	8.9 (37)	10.9 (321)
Psychiatric Casework	8.0 (141)	7.9 (18)	2.1 (4)	4.2 (6)	1.8 (5)	17.5 (73)	8.2 (247)
Administration	19.6 (344)	15.9 (36)	22.2 (42)	22.7 (32)	21.9 (60)	39.2 (163)	22.6 (677)
Teaching	9.1 (160)	11.0 (25)	7.9 (15)	12.1 (17)	14.2 (39)	11.5 (48)	10.1 (304)
Research	2.7 (47)	3.1 (7)	3.7 (7)	4.3 (6)	5.8 (16)	4.3 (18)	3.4 (101)
Total	100% (1754)	100% (227)	99.9% (189)	100% (141)	99.9% (274)	99.9% (416)	100% (3001)
Percent of Total Sample	58.4%	7.6%	6.3%	4.7%	9.1%	13.9%	

*No Answer and Out of Field = 991

[a]The most frequent responses included in this category were "Psychoanalytic," "Freudian," "Adlerian," and "Jungian."

[b]The most frequent responses in this category were "Ego-Psychology," "Neo-Freudian," "Fromm," "Horney" and "Erikson."

[c]The most frequent responses in this category were "Sullivanian," "Interpersonal" and "W.A. White."

[d]The content of this category is composed of those who gave "Eclectic" as their major orientation.

[e]The most frequent responses in this category were "Rogerian," "Client-Centered," "Non-Directive," "Existential" and "Experiential."

[f]The most frequent responses in this category were "Social-Community," "Social Psychiatric," "Community," "Milieu" and "Social Psychological."

It is clear from this table that the dominant ideology in the field is Psychoanalytic and that adherents to this position, like adherents to the less popular orientations, perform a wide range of functions. Thus, although the numbers in some cells are small, a sizable proportion of adherents to each of the ideologies is found in each type of activity. However, while the members of the various ideological camps are much more uniformly distributed among the various functions than was true for the various professions, a certain degree of specialization is evident. Thus, for five of the ideological categories, therapy is the single most frequently mentioned activity. The one exception, the Social-Community orientation, has the largest single concentration of adherents in administrative positions. The striking thing about this pattern of specialization among ideologies is the consequence it has for the distribution of professionals engaged in therapy. Specifically, as one moves from the traditional psychodynamic orientation represented by the Psychoanalytic ideology toward the more interpersonally directed Social-Community ideology, the proportion of adherents engaged in therapy decreases. When these findings are placed in the context of the recent proliferation of mental health ideologies, the implication becomes clear: the greatest impact of the newer ideologies has been on nontreatment functions, particularly administration, while the "core act" of therapy is still largely dominated by traditional ideologies.

In general, then, the major ideologies in the mental health field are differentially related to the functions performed by professionals. Moreover, the influences of therapeutic ideologies on major job activities are different from the influences stemming from professional affiliation. Since it is in the various work settings that representatives from the

several professional specialties and ideological camps are brought together, it is at this point that professional roles are consolidated. The characteristics of the work setting, then, not only influence directly the functions performed but also indirectly condition the influences stemming from professional training and ideological commitment. Therefore, data on institutions employing mental health professionals can provide clues on how the various groups work out a division of labor and responsibility toward both the treatment process and various auxiliary roles. Table 4, showing the distribution of functions in the various types of institutions employing members of the four mental health professions, provides this evidence.[15]

Table 4 about here

It should be pointed out at the outset that more than one-third of mental health professionals are in private practice. Educational institutions, employing one-sixth of the professionals, are the second most important work settings. It seems clear that in spite of the recent emphasis on outpatient clinics and other community mental health facilities, private practice is still the career route for a large number of mental health practitioners. Further, as a consequence of this situation we find that therapy is still predominately done in private practice. While this in itself may not be surprising, the overwhelming concentration of professionals in private practice is impressive. Specifically, of all professionals giving

TABLE 4

RELATIONSHIP BETWEEN WORK SETTING AND MAJOR JOB ACTIVITY

Major Job Activity	Work Setting: Service Organization[a]	Educational Institution[b]	Health Related Institution[c]	General Hospital[d]	Mental Hospital	Psychiatric Clinic	Private Practice	Total*
Therapy	9.0% (31)	6.6% (39)	17.1% (48)	17.2% (74)	28.8% (34)	29.6% (146)	96.1% (1256)	45.8% (1628)
Counseling	35.1 (121)	10.1 (58)	10.3 (29)	9.8 (42)	14.4 (17)	13.0 (64)	3.9 (51)	10.8 (382)
Psychiatric Casework	10.4 (36)	1.6 (9)	13.9 (39)	24.4 (105)	5.1 (6)	12.6 (62)	--- ---	7.2 (257)
Administration	36.8 (127)	21.7 (125)	49.8 (140)	35.6 (153)	43.2 (51)	38.5 (190)	--- ---	22.1 (786)
Teaching	3.8 (13)	48.0 (277)	4.3 (12)	7.4 (32)	2.5 (3)	4.7 (23)	--- ---	10.1 (360)
Research	4.9 (17)	11.9 (69)	4.6 (13)	5.6 (24)	5.9 (7)	1.6 (8)	--- ---	3.9 (138)
Total	100% (345)	99.9% (577)	100% (281)	100% (430)	99.9% (118)	100% (493)	100% (1307)	99.9% (3551)
Percent of Total Sample	9.7%	16.2%	7.9%	12.1%	3.3%	13.9%	36.9%	

*No Answer = 441

[a]This category is composed of the following types of organizations: public and private schools, public and private welfare organizations and public and private community service organizations.

[b]This category includes colleges and universities, including medical schools and counseling centers and professional training institutes.

[c]This category includes public and private homes for children and the elderly and health and mental health associations and foundations.

[d]This category includes public and private general hospitals not specializing in the treatment of mental illness.

therapy as a major job activity, the number in private practice is more than twice as large as the number working in all types of institutions combined. Even when therapy is combined with counseling and casework, the number of professionals engaged in any form of treatment is still larger in private practice than in all other settings combined. Clearly, as a full time job, treatment is still the province of private practitioners. Similarly, with regard to other types of functions, considerable specialization by type of institution is evident. Thus, research and teaching is still largely confined to educational institutions. This is to be expected; however, the fact that psychiatric clinics, which are presumably in the mainstream of current innovations in the mental health field, have the smallest proportion of professionals engaged in research is surprising. Further, this finding on psychiatric clinics cannot be accounted for by assuming that the majority of professionals working in this setting are involved in therapy. In fact, it is administrative functions and not treatment functions that are the most frequently mentioned activities of professionals working in clinics. Moreover, administration is also the largest single category for all types of organizations, except educational institutions. It seems clear that one of the direct influences of institutional settings on the distribution of labor in the mental health field is to draw professionals away from treatment careers and into careers in mental health organizational administration. Finally, since clinical psychology and psychiatric social work have by far the smallest proportion of persons engaged in therapy, it appears that these two professions have been accepted in all types of mental health organizations; but their contribution is confined to activities other than psychotherapy. Further support for this possibility comes from the fact that less than

one-third of the professionals in each type of institution are engaged in therapy. Even when therapy is combined with counseling and psychiatric casework the highest proportion of professionals engaged in treatment in any type of setting is only slightly more than one-half. This suggests that a large proportion of treatment occurring in mental health institutions is done by professionals on a part-time basis. Hence, a major distinction within mental health institutions is between treatment, frequently conducted on a part-time basis, and internal organizational functions, conducted by professionals as a major job activity. These findings, taken as a whole, suggest that the lines of specialization are drawn between medically trained professionals who do therapy in private practice and nonmedical professionals who engage in administration and non-intensive client contact in organizations.

Having seen that professional affiliation, ideological identification and work setting are each strongly associated with the distribution of professional functions in the mental health field, the remaining step is to assess how these variables inter-relate to form a single causal network. Although multivariate correlational analysis is frequently used to answer such questions, the danger of spurious correlation is inherent in this technique. However, Simon has introduced a method, later expanded by Blalock, for making inferences from correlational data that minimizes the danger of spuriousness. Essentially, this procedure provides a means for linking several diverse variables into a single network of inter-relationships and determining the direction of interaction between them.[16] The general form of this scheme will be used to explore the relationship between professional designation, ideological identification, work setting and major job activity.[17]

In order to explore the relationship between each of the four professions and the various major job activities, each category of each variable

was dichotomized so that only those respondents who included themselves under a given label were given a positive score. Using the multiple regression technique, each of these dichotomies was used to predict the various job activities. The same procedure was used to predict job activities by the various categories of ideological identification and by the various categories of work setting.[18] The variables were then combined to assess the interaction among them and the manner in which they formed a single network of relationships influencing the distribution of functions in the mental health field. Tables 5, 6 and 7 show the influence of the variables taken independently on the distribution of professional functions.

Tables 5, 6, and 7 about here

As revealed in Table 5, professional designation is significantly related to major job activity but the influence of each profession varies for each of the various functions. Psychoanalysts, clinical psychologists and psychiatrists are each strongly associated with therapy and together they account for sixteen percent of the variance in this function.[19] The professions of psychiatry and psychoanalysis are also the strongest predictors of counseling. For psychiatric casework the two medical professions reverse the preceding order of predictability with psychoanalysis being most strongly related and psychiatry second. Finally, administration is the sole province of psychiatric social work while teaching is best predicted by psychiatry and research by psychoanalysis. Thus, while the relationships are not strong there is a clear division of labor along professional lines.

TABLE 5

THE PREDICTION OF MAJOR JOB ACTIVITY FROM PROFESSIONAL DESIGNATION

Dependent Variable	Independent Variable	Partial r	Proportion of Variance (Mul. r^2) (Cumulative)	F Value (Cumulative)
Therapy	Psychoanalyst	.275	.076	327.79 *
	Psychologist	.241	.123	279.06 *
	Psychiatrist	.221	.165	263.65 *
Counseling	Psychiatrist	-.110	.008	31.89 *
	Psychoanalyst	-.109	.020	40.19 *
Psychiatric Casework	Psychoanalyst	-.147	.014	57.18 *
	Psychiatrist	-.145	.035	72.26 *
Administration	Psychiatric Social Worker	.161	.026	106.42 *
Teaching	Psychiatrist	-.061	.004	15.04 *
Research	Psychoanalyst	-.048	.002	9.27 *

* = significant at the .025 level. Since F values are cumulative, d.f.=1/3991, 2/3990, etc. Variables are included only if theyaccount for at least 1 per cent of the residual variance.

TABLE 6

THE PREDICTION OF MAJOR JOB ACTIVITY BY IDEOLOGICAL SELF DESIGNATION

Dependent Variable	Independent Variable	Partial r	Proportion of Variance (Mul. r^2) (Cumulative)	F Value (Cumulative)
Therapy	Social-Community	-.183	.031	127.76 *
	Rogerian	-.104	.042	86.51 *
Counseling	Rogerian	.163	.026	108.69 *
Psychiatric Casework	Social-Community	.133	.018	72.09 *
Administration	Social-Community	.141	.020	80.93 *
Teaching	Rogerian	.035	.001	5.00
Research	Somatic-Organic	.082	.007	27.35 *

* = significant at the .025 level. Since F values are cumulative, d.f.=1/3991, 2/3990, etc. Variables are included only if they account for at least 1 per cent of the residual variance.

TABLE 7

THE PREDICTION OF MAJOR JOB ACTIVITY
BY WORK SETTING

Dependent Variable	Independent Variable	Partial r	Proportion of Variance (Mul. r^2) (Cumulative)	F Value (Cumulative)
Therapy	Private Practice	.765	.576	5430.59 *
	Psychiatric Clinic	.172	.589	2857.78 *
Counseling	Service Organization	.154	.024	97.54 *
Psychiatric Casework	General Hospital	.207	.059	250.04 *
	Private Practice	-.130	.075	161.72 *
Administration	Private Practice	-.327	.124	566.62 *
	Health Related Institution	.133	.140	324.04 *
Teaching	Educational Institution	.537	.288	1615.84 *
Research	Educational Institution	.179	.032	131.99 *

* = significant at the .025 level. Since F values are cumulative, d.f.=1/3991, 2/3990, etc. Variables are included only if they account for at least 1 per cent of the residual variance.

Turning to ideological identification (Table 6), we find that, in general, treatment ideology accounts for less of the variance in the categories of major job activity than was true of professional affiliation. Moreover, only three of the seven ideological positions bear any relationship to the activities. Even more striking is the fact that these three ideological categories represent extremely different positions in the mental health field and they do not include the dominant ideology, psychoanalytic. Thus, while ideology is a relatively weak predictor of the division of labor in the mental health field, there is a discernible relationship between particular ideologies and particular functions.

Work setting, as shown in Table 7, is the best single predictor of the division of labor in the mental health field in that it accounts for the largest proportion of variance in five out of the six major job activities. Work setting also differs from professional affiliation and ideological identification in that each type of major job activity is positively correlated with at least one type of setting. This means that it is possible to state which activities are concentrated in each type of institution rather than which activities are avoided, as was the case for profession and ideology. Thus, work setting provides a more precise measure of specialization than was true of professional affiliation and ideological identification.

Having seen that the various categories of professional designation, ideological identification and work setting are differentially related to professional functions in the mental health field, the remaining step is to assess how these variables inter-relate to form a single causal network. Table 8 presents the multiple regression of professional affiliation, therapeutic ideology and work setting against major job activities.

Table 8 about here

Previous data has shown that the performance of therapy as a major job activity was significantly associated with each of the following variables when analyzed independently: (a) professional designation of psychoanalyst, psychologist and psychiatrist, (b) social-community and Rogerian ideology and, (c) working in private practice or psychiatric clinic. If each of these variables exercised an independent influence we might expect the total amount of variance accounted for when all three are used to be equal to the sum of the amounts obtained for each used separately. However, Table 8 reveals that when these three variables are combined,only private practice and psychiatric clinic work settings emerge as being associated with the performance of therapy. There are two alternative explanations possible for this discrepancy. First, it is possible that the original associations between profession and the performance of therapy and between ideology and therapy were each spurious relationships caused by these factors being related to some third variable. Second, it is possible that the association between profession and therapy and ideology and therapy is mediated by work setting as an intervening variable. The decision between these alternatives can be made by taking the temporal occurrence of these variables into account. That is, it seems likely that of the three sets of variables in this regression, professional affiliation is acquired first, followed by ideological adherence, and that both of these processes precede moving into private practice or psychiatric clinics. Selecting one of these two work settings then, is the

TABLE 8

THE PREDICTION OF MAJOR JOB ACTIVITY BY PROFESSIONAL DESIGNATION, THERAPEUTIC IDEOLOGY AND WORK SETTING

Dependent Variable	Independent Variable	Partial r	Proportion of Variance (Mul. r^2) (Cumulative)	F Value (Cumulative)
Therapy	Private Practice	.765	.576	5430.59 *
	Psychiatric Clinic	.172	.589	2857.78 *
Counseling	Rogerian Ideology	.146	.026	108.69 *
	Service Organization	.136	.046	93.09 *
Psychiatric Casework	General Hospital	.201	.059	250.04 *
	Private Practice	-.130	.075	161.72 *
Administration	Private Practice	-.327	.124	566.62 *
	Health Related Institution	.133	.140	324.04 *
Teaching	Educational Institution	.537	.288	1615.84 *
Research	Educational Institution	.179	.032	131.99 *

* = significant at the .025 level. Since F values are cumulative, d.f.=1/3991, 2/3990, etc. Variables are included only if they account for at least 1 per cent of the residual variance.

result, rather than the cause, of professional affiliation and ideological identification. Thus, it is likely that neither the original relationship between profession and therapy nor the relationship between ideology and therapy was spuriously caused by both being the product of some third variable. We are led to conclude that the relationship between profession, ideology and therapy is mediated by work setting, operating as an intervening variable. Psychoanalysts, clinical psychologists and psychiatrists and adherents of some ideology other than social-community or Rogerian, therefore, perform therapy as a major job activity only to the extent that they work in private practice or psychiatric clinics.

For the prediction of counseling the table shows that both ideology and work setting are associated. Here, the original relationship between professional designation, taken alone, and counseling has vanished. Since professional affiliation was negatively associated with counseling this is not surprising. However, since choice of both an ideology and a work setting are the result rather than the causes of professional choice, it seems unlikely that the original relationship between profession and counseling was spurious. We can conclude, then, that the influence of professional affiliation on engaging in counseling as a major job activity is mediated by a particular ideology (Rogerian) and a particular work setting (service organization). Specifically, nonmedical professionals engage in counseling to the extent that they adhere to a Rogerian ideology and/or work in service organizations.

In the prediction of psychiatric casework we found that both profession and ideology were significantly associated when analyzed independently, but these relationships vanish when work setting is combined with these two variables. Using the same reasoning as before, we are led to

conclude that nonmedical professionals and those adhering to a Social-Community ideology engage in psychiatric casework only to the extent that they work in general hospitals.

For administrative activities, including ideology and professional affiliation adds nothing to the fourteen per cent of the variance accounted for by work setting alone. Thus, while psychiatric social work and Social-Community orientation were both significantly associated with administration when analyzed independently, neither relationship holds when combined with setting. Here the influence of professional affiliation and ideological adherence is clearly mediated by work setting. Specifically, psychiatric social workers and adherents to the Social-Community ideology engage in administrative functions on a full-time basis only to the extent that they work in Health Related institutions and not in private practice.

Finally, for both teaching and research, profession and ideology were associated when analyzed separately but drop out when the two variables are combined with work setting. Similarly, in each case the negative correlations on profession indicate that one of the medical groups avoid engaging in these two activities, although in each case the profession is different. However, the correlations between ideology and both teaching and research are positive. Thus, we are able to infer that adherents of the Rogerian ideology and professionals other than psychiatrists engage in teaching to the extent that they are employed in educational institutions. Similarly, adherents of the Somatic-Organic or medical orientation and professionals other than psychoanalysts engage in research to the extent that they work in educational institutions.

In sum, the data indicate that knowledge of work setting is the best predictor of the distribution of mental health professionals in five out of the six types of functions analyzed. This does not imply that professional affiliation and ideological designation are unimportant but that their influence can best be understood by controlling for type of work setting. This conclusion is made evident by the regression technique used in the analysis. In this procedure the first variable extracted is the most important, measured by the proportion of variance accounted for by it. This variable is essentially held constant and the question asked then is what variable accounts for the largest proportion of the remaining variance in the dependent variable. For all major job activities, except counseling, one of the categories of work setting was the first variable extracted. It seems clear, then, that knowledge of the type of setting is a prerequisite to understanding the influence of ideological adherence and professional training on the distribution of functions among mental health professionals in metropolitan service areas.

Conclusions and Implications

From a general perspective, the mental health field is a specific case of the group of professional fields which have recently undergone rapid increases in both size and social significance. As such, it shares many characteristics with other professional fields such as adult education and social welfare. Specifically, three major trends stand out as basic characteristics common to all these fields. These include: a) the proliferation of practitioners from diverse professional specialties claiming a right to perform core functions, b) the rise of new ideologies which frequently become the basis for competing camps (or subcultures) in these fields, and

c) innovations in the settings of professional practice. While these changes have been underway for some time, there have been few corresponding changes in the models used to study professional behavior in these fields. For these reasons, it seems worthwhile to examine the major implications of the present study for the development of research strategies in the field of adult education.

The first, and most general, implication concerns the variables to be used in the study of a professional field. The trends in both mental health and adult education indicate that the influence of professional training and affiliation on the allocation of professional roles is diminishing. In addition, the findings from the present study clearly demonstrate that compared to other variables, professional affiliation is a relatively weak predictor of professional behavior. The significance of this is twofold. First, it suggests that developments in these fields can be fully understood only by giving increased attention to professional behavior rather than restricting the focus solely to professional attitudes and value orientations. Only in this way will it be possible to investigate such basic issues as the results of the increasing overlap in functions performed by various professionals and the concomitant "role blurring".[20] Specifically, it could facilitate the coordination of professional efforts or, conversely provide a major source of inter-professional and intra-professional conflict. The second, and related point is that studies of professionalization and professional socialization provide little data on the current practices of professionals in such rapidly changing fields as adult education. The relevant issues in these fields are more related to which functions are performed by members of the profession and in which settings rather than where a professional

group stands vis-a-vis others on a scale of professionalism. The situation of psychiatrists and psychoanalysts in the present study is instructive. These represent two of the most professionalized groups in the occupational structure, yet these professional affilitations indicate only which functions are avoided by practitioners in institutions rather than indicating functions are performed. In sum, it seems clear that the rise of professional specialization in fields like mental health and adult education will necessitate including the study of behavior in future research on professionals.

The findings on the relative influence of profession, ideology and work setting on the distribution of functions in the mental health field also has consequences for the development of research strategies in adult education. Specifically, since the data indicated that work setting was the best predictor of the division of labor in the mental health field, we are led to conclude that the influence of professional training and the influence of professional value orientations and ideologies can be assessed most precisely within institutional contexts. Thus, professional specialization undoubtedly is related to recruitment into various types of institutions. Similarly, examination of the mechanisms of "institutional socialization" would undoubtedly provide a great deal of information on the relationship between professional training and the performance of various functions. Equally plausible is the possibility that the structure, function and composition of institutions more strongly affect professional behavior than do differences in the specific programs conducted within them. Finally, with regard to ideologies, it seems less important to discover whether a particular value orientation cross-cuts an entire

profession than it is to discover what, if any, ideology dominates an institution and whether the institutional ideology is the product of selective recruitment or of organizational pressures. While these are just a few of the questions raised by the present study, they are sufficient to illustrate the major point: specialization has reached the point in fields such as mental health and adult education where the meaningful variance is within professions and ideologies rather than between them.

The second implication concerns the general model used to study professional behavior. While the specific variables of professional affilitation, treatment ideology and work setting were used in the present study, the findings suggest that these factors may be subsumed under two general dimensions. The first dimension refers to what might be called "structural constraints" on professional behavior and was measured in the present study by general type of institutional setting. The second dimension refers to what might be termed "normative constraints" on professional behavior and includes various mechanisms of social control which are acquired and internalized through professional socialization experiences. In the present study normative constraints were measured by both professional affilitation and ideological identification. Although these two analytic dimensions seem to be basic to the study of professional behavior, it is equally clear that a wide variety of indices can be used for their measurement. Thus, structural constraints might include such factors as bureaucratic structure, dominant functions, selective recruitment, size and historical character of organizations. Similarly, normative constraints might include and examination of professional

values, ethics, socialization experiences, ideological indoctrination and theoretical orientation.

The third, and final, implication concerns the ecological perspective in the study of professional fields. That is, the present study surveyed the total population of professional therapeutic personnel working in three metropolitan communities. The metropolitan community was selected as the sample unit because it most closely approximates an autonomously functioning "service area" possessing the full range of personnel and facilities utilized in treating mental illness. The metropolitan community, therefore, provides a microscopic representation of the mental health field as a whole. Since research on any rapidly changing professional field requires investigating the full range and diversity of roles, interests and settings, broading the scope of research to include entire metropolitan communities would seem to be one way to increase the precision of findings in such area. In view of the fact that metropolitan communities appear to be comparable in terms of professional services and programs it thus becomes possible to study one community with some assurance that the findings are indictative of trends in the field.

FOOTNOTES

[1]See, for example, August B. Hollingshead and Frederich C. Redlich, Social Class and Mental Illness: A Community Study (New York: John Wiley & Sons, Inc., 1959); Doris C. Gilbert and Daniel J. Levinson, "Custodialism and Humanism in Mental Hospital Structure and Staff Ideology," in Milton Greenblatt, Daniel J. Levinson, and Richard H. Williams (eds.) The Patient and the Mental Hospital (Glencoe, Ill.: The Free Press, 1957); Myron R. Sharaf and Daniel J. Levinson, "Patterns of Ideology and Role Definition among Psychiatric Residents," ibid; Anselm Strauss et al., Psychiatric Ideologies and Institutions (New York: The Free Press, 1964).

[2]Alvin Zander, Arthur Cohen and Ezra Stotland, Role Relations in the Mental Health Professions (Ann Arbor, Mich.: University of Michigan Research Center for Group Dynamics, Institute for Social Research, 1957); William A Rushing, The Psychiatric Professions: Power, Conflict and Adaptation in a Psychiatric Hospital Staff (Chapel Hill, N.C.: The University of North Carolina Press, 1964).

[3]A. H. Stanton and M.S. Schwartz, The Mental Hospital (New York: Basic Books, 1954); Harvey Smith, "Professional Strains in the Hospital Context," in Milton Greenblatt, Daniel J. Levinson and Richard H. Williams (eds.) op. cit.; Anselm Strauss et al., op. cit.; William A Rushing, op. cit.

[4]August B. Hollingshead and Frederich G. Redlich, op. cit.; Doris C. Gilbert and Daniel J. Levinson, op. cit.; Myron R. Sharaf and Daniel

J. Levinson, ibid.; Gerald L. Klerman, "Sociopsychological Characteristics of Resident Psychiatrists and Their Use of Drug Therapy," American Journal of Psychiatry, CXVII, No. 2 (August, 1960), pp. 111-17.

[5]August B. Hollingshead and Frederich G. Redlich, op. cit.; Doris C. Gilbert and Daniel J. Levinson, op. cit.; Myron R. Sharaf and Daniel J. Levinson, ibid.

[6]Anselm Strauss et al., op. cit.

[7]The first, and most extensive, study of interprofessional relations starting with this assumption was Alvin Zander, Arthur R. Cohen and Ezra Stotland, op. cit.

[8]See, for example, Harvey Smith, op. cit.; Martin Loeb, "Role Definitions in the Social World of the Psychiatric Hospital," ibid.; A. H. Stanton and M. S. Schwartz, op. cit.

[9]See, for example, Anselm Strauss et al., op. cit.; William A Rushing, op. cit.

[10]The findings from a survey of psychiatric organizations conducted by the Orthopsychiatric Association provides confirmation of this point. Of the 327 organizations in the sample studied, 49 per cent had five or fewer full-time professional staff members. Wide differences were also found in the functions performed by the various mental health professionals in the various types of psychiatric institutions. Cf. Morris Krugman et al., "A Study of Current Trends in the Use and Coordination of Professional Services of Psychiatrists, Psychologists and Social Workers in Mental Hygiene Clinics and Other Psychiatric Agencies and Institutions," The

American Journal of Orthopsychiatry, XX, No. 1 (January, 1950) pp. 1-62.

[11]For purposes of the survey, the Chicago Metropolitan Community was defined as the area referred to as the Chicago Standard Metropolitan Statistical Area and the Gary-Hammond-East Chicago Standard Metropolitan Statistical Area in the 1960 Census. The Los Angeles Metropolitan Community consists of Los Angeles County which contains within it the Los Angeles-Long Beach Standard Metropolitan Statistical Area. Finally, the New York Metropolitan Community consists of Manhattan and the four adjoining boroughs.

[12]Specifically, for psychiatrists the 1963 edition of the Biographical Directory of the American Psychiatric Association was used. This directory also provided information on those psychiatrists who had graduated from or were currently attending a Psychoanalytic Institute recognized by the American Psychoanalytic Association. Since both prior research and offical professional statements indicated that psychoanalysts represent a discrete specialty in the mental health field they were treated as a separate professional group. The current annual edition of the Directory of the American Psychological Association was used to obtain the population of psychologists. Those who listed as "interests" in their autobiographical sketches in the Directory any of the following area concerned with mental health were included in the sample: Psychodrama, Hypnodrama, Family Therapy, Psychotherapeutic Technique, Marriage and Family Therapy, Psychological Counseling, Nondirective Counseling and Clinical. For psychiatric social workers the existing Directory of Professional Social Workers could not be used in Chicago and Los Angeles because it was outdated at the time of the survey. However, it was possible to obtain a list of "qualified,

experienced" psychiatric social workers from the local chapters of the National Association in the two cities. For New York the 1966 Directory of Professional Social Workers, issued just prior to the survey, was used to define the population of psychiatric social workers. When necessary, this latest edition of the Directory was supplemented with information drawn from the Directory of Social and Health Agencies of New York City--1965-66.

[13]A full understanding of the relationship between ideology and major job activities obviously requires some infomration on the distribution of orientations among the various professions. The following brief description of the distribution of orientations in the four professional groups is presented to meet this requirement. First, of the 483 psychoanalysts giving an orientation , 83 per cent said " Psychoanalytic," 7 per cent "Neo-Freudian," 2 per cent "Sullivanian," 1 per cent "Rogerian-Existential," 2 per cent "Eclectic," 4 per cent "Social-Community," and 1 per cent "Somatic-Organic." For the 580 psychiatrists answering, the distribution was as follows: 51 per cent "Psychoanalytic," 8 per cent "Neo-Freudian," 6 per cent "Sullivanian," 3 per cent "Rogerian-Existential," 10 per cent "Eclectic," 13 per cent "Social-Community," and 9 per cent "Somatic-Organic." The distribution for the 1136 clinical psychologists who answered the question was as follows: 47 per cent "Psychoanalytic," 9 per cent "Neo-Freudian," 10 per cent "Sullivanian," 21 per cent "Rogerian-Existential," 5 per cent "Eclectic," 7 per cent "Social-Community," and 1 per cent "Somatic-Organic." Finally, for the 1057 social workers answering the question the distribution was as follows: 58 per cent "Psychoanalytic," 5 per cent "Neo-Freudian," 3 per cent"Sullivanian," 3 per cent "Rogerian-Existential," 3 per cent "Eclectic," 27 per cent "Social-Community," and 1 per cent "Somatic-Organic."

It should be noted that one important ideological category, the "Somatic-Organic" or "Pharmacologic" is not included in Table 3. The reason for this is that only 74 of the respondents indicated that this approach was their major therapeutic orientation. Since the category was too small for analysis the respondents giving this orientation were dropped from the table.

[14]Since this includes members of four professional groups there was no precedent for anticipating the distribution of responses to this questionnaire item and for establishing prior code categories. As a result, the responses were coded separately and the ideological categories established inductively. The establishment of the categories took into consideration both the distribution of responses within each of the four professional groups as well as the overlaps between the four distributions. These categories were then subsumed under appropriate labels about which there is a relatively high degree of consensus among professional mental health practitioners.

It should be pointed out that what is being measured is not the substantive content of the therapeutic orientations, but rather certain generally agreed upon labels which refer to various sets of beliefs about mental illness and treatment. Thus, no attempt is being made to assess the therapeutic systems themselves. All that is being measured is which ideological systems respondents are committed to and form the basis of their therapeutic orientations.

[15]Briefly, members of the four professional groups were distributed among the various work settings in the following manner. First, of the 589 psychoanalysts who indicated their work setting, 76 per cent were

in private practice, 1 per cent in service organizations, 4 per cent in general hospitals, 2 per cent in mental hospitals, 11 per cent in educational institutions, 2 per cent in health related institutions, and 4 per cent in psychiatric clinics. For the 662 psychiatrists the distribution was: 56 per cent in private practice, 4 per cent in service organizations, 11 per cent in general hospitals, 7 per cent in mental hospitals, 10 per cent in educational institutions, 5 per cent in health related institutions, and 6 per cent in psychiatric clinics. For the 1391 clinical psychologists the distribution was: 33 per cent in private practice, 17 per cent in service organizations, 8 per cent in general hospitals, 3 per cent in mental hospitals, 24 per cent in educational institutions, 5 per cent in health related institutions, and 10 per cent in psychiatric clinics. Finally, for the 1103 psychiatric social workers the distribution was: 11 per cent in private practice, 11 per cent in service organizations, 21 per cent in general hospitals, 2 per cent in mental hospitals, 11 per cent in educational institutions, 16 per cent in health related institutions, and 28 per cent in psychiatric clinics.

[16]Herbert A. Simon, "Spurious Correlation: A Causal Interpretation." Journal of American Statistical Association, 49 (September, 1954), pp467-79; H.M. Blalock, "Correlational Analysis and Causal Inferences," American Anthropologist, 62 (August, 1960) , pp. 624-31; H. M. Blalock, "Correlation and Causality: The Multivariate Case," Social Forces, 39 (March, 1961), pp. 246-51; H.M. Blalock, "Evaluating the Relative Importance of Variables," American Sociological Review, 26 (December, 1961), pp. 866-74.

[17]The statistical technique Blalock has developed employs a "Goodness

of Fit" test for assessing the adequacy of a hypothesized causal model. This test cannot be used on the data for this study because the variables are not single quantitative indices. The general form of Blalock's scheme can be used, however, and the statistical findings given by the multiple regression procedure will provide evidence on the strength of each set of relationships.

[18]This procedure produces a series of variables with rectangular distributions and,hence, does not meet the assumption of normal distribution and homogeneity of variance required by the regression statistic. However, Lindquist has shown empirically that using the .025 level of significance effectively accounts for the discrepancy introduced by this violation and insures that the risk of error is less than five per cent. Hence, the significant level of .025 will be used throughout this analysis. For a discussion of the evidence supporting this procedure, see E.F. Lindquist, Design and Analysis of Experiements in Psychology and Education. (Boston: Houghton Mifflin Company, 1953) pp. 78-90.

[19]In the regression technique used the most important variable, measured by the proportion of variance accounted for, is always extracted first and appears first in the table. The next variable removes is the one that accounts for the major portion of the remaining variance, etc. This means that if two variables are correlated highly only one will appear to account for a large proportion of the variance. The second variable included, then, will account only for a portion of the variance that does not overlap with the variable that has proceded it. Since variables were not included in the table if they did not account for at least one per cent of the residual variance it is possible that some

variables will not appear.

[20]For a definition and discussion of the concept of "role blurring" see Elaine Cumming, " Allocation of Care to the Mentally Ill, American Style," in Mayer Zald (ed.), Organizing for Community Welfare (Chicago: Quadrangle Books, 1967).

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